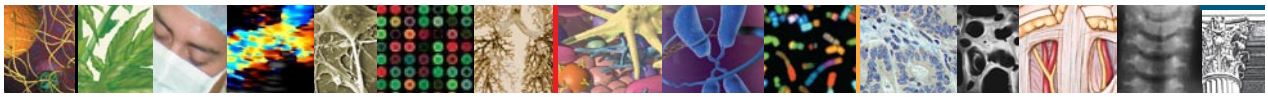

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Perspective

Carrots, Sticks, and Health Care Reform — Problems with Wellness Incentives

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Chronic conditions, especially those associated with overweight, are on the rise in the United States (as elsewhere). Employers have used both carrots and sticks to encourage healthier behavior.

The current health care reform bills seek to expand the role of incentives, which promise a win–win bargain: employees enjoy better health, while employers reduce health care costs and profit from a healthier workforce.

However, these provisions cannot be given an ethical free pass. In some cases, the incentives are really sticks dressed up as carrots. There is a risk of inequity that would further disadvantage the people most in need of health improvements, and doctors might be assigned watchdog roles that might harm the therapeutic relationship. We believe that some changes must be made to reconcile incentive use with ethical norms.

Under the 1996 Health Insurance Portability and Accountability Act (HIPAA), a group health plan may not discriminate among individuals on the basis of health factors by varying their premiums. But HIPAA does not prevent insurers from offering reimbursements through "wellness programs." These include what could be called participation incentives, which offer a premium discount or other reimbursement simply for participating in a health-promotion program, and attainment incentives, which provide reimbursements only for meeting targets — for example, a particular body-mass index or cholesterol level. Subsequent regulations specified that attainment incentives must not exceed 20% of the total cost of an employee's coverage (i.e., the combination of the employer's and employee's contributions).[1]

The health care reform measures currently before Congress would substantially expand these provisions (see box). However, ethical analysis and empirical research suggest that the current protections are inadequate to ensure fairness.

Attainment incentives provide welcome rewards for employees who manage to comply but may be unfair for those who struggle, particularly if they fail. The law demands the provision of alternative standards for those who cannot or should not participate because of medical conditions, but those categories are narrowly defined. For all others, the implicit assumption is that they can achieve targets if they try. This assumption is hard to reconcile with what we know about lifestyle change.

Summary of Wellness Incentives in the Current Legislation.

The "Affordable Health Care for America Act" (House of Representatives), section 112, requires that qualifying programs:

- Be evidence-based and certified by the Department of Health and Human Services
- Provide support for populations at risk for poor health outcomes
- Include designs that are "culturally competent [and] physically and programmatically accessible (including for individuals with disabilities)"
- Be available to all employees without charge
- Not link financial incentives to premiums
- Entail no cost shifting

The "Patient Protection and Affordable Care Act" (Senate), section 2705, proposes to increase reimbursement levels to 30% of the cost of employee-only coverage, or up to 50% with government approval. In part restating provisions for current wellness programs, it also requires that qualifying programs:

- Be "available to all similarly situated individuals"
- Have "a reasonable chance of improving the health of, or preventing disease in, participating individuals"
- Not be "overly burdensome, [be] a subterfuge for discriminating based on a health status factor, [or be] highly suspect in the method chosen to promote health or prevent disease"
- Provide an alternative standard for employees whose medical condition — as certified by a physician — precludes participation in attainment-incentive programs
- Not pose an "undue burden for individuals insured in the individual insurance market"
- Entail no cost shifting
- Be evaluated in pilot studies and a 10-state demonstration project

Most diets, for example, do not result in long-lasting weight reduction, even though participants want and try to lose weight. Attainment-incentive programs make no distinction between those who try but fail and those who do not try.

Proponents of attainment incentives typically do not view this situation as inequitable. Steven Burd, the chief executive officer of Safeway, whose "Healthy Measures" program offers reimbursements for meeting weight, blood-pressure, cholesterol, and tobacco-use targets, compared his company's program to automobile insurance, in which for decades "driving behavior has been correlated with accident risk and has therefore translated into premium differences among drivers." In other words, says Burd, "the auto-insurance industry has long recognized the role of personal responsibility. As a result, bad behaviors (like speeding, tickets for failure to follow the rules of the road, and frequency of accidents) are considered when establishing insurance premiums. Bad driver premiums are not subsidized by the good driver premiums."[2]

If people could lose weight, stop smoking, or reduce cholesterol simply by deciding to do so, the analogy might be appropriate. But in that case, few would have had weight, smoking, or cholesterol problems in the first place. Moreover, there is a social gradient. A law school graduate from a wealthy family who has a gym on the top floor of his condominium block is more likely to succeed in losing weight if he tries than is a teenage mother who grew up and continues to live and work odd jobs in a poor neighborhood with limited access to healthy food and exercise opportunities. And he is more likely to try. In Germany, where both participation and attainment incentives have been offered since 2004, participation rates among people in the top socioeconomic quintile are nearly double the rates among those in the poorest quintile.[3]

Incentive schemes are defended on the grounds of personal responsibility, but as Kant observed, "ought" implies "can." Although alternative standards must be offered to employees for whom specific targets are medically inappropriate, disadvantaged people with multiple coexisting conditions may refrain from making such petitions, seeing them as degrading or humiliating. These potential problems are important in view of the proposed increases in reimbursement levels.

The reform proposals prohibit cost shifting, but provisions in the Senate bill could result in a substantial increase in financial burden on employees who do not meet targets (or alternative standards). On the basis of the average cost of $4700 for employee-only coverage, a 20% incentive amounts to $940; 30% would equal $1410 and 50%, $2350. In practice, insurers may stay below the maximum levels. Some may elect to absorb the full cost of reimbursements, in part because some or all of these costs may be offset by future savings from a healthier workforce. Alternatively, however, insurers might recoup some or all of the costs by increasing insurance contributions from insurance holders. In the extreme case, the incentive

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might then simply consist of being able to return to the previous level of contributions. Similar effects can be achieved by varying applicable copayments or deductibles.[4] Direct and indirect increases would disproportionately hurt lower-paid workers, who are generally less healthy than their higher-paid counterparts and thus in greater need of health care, less likely to meet the targets, and least likely to be able to afford higher costs. Some employees might decide to opt out of employer-based health insurance — and indeed, one wellness consulting firm, Benicomp, implies in its prospectus that such a result might be desirable, pointing out that employees who do not comply might be "motivated to consider other coverage options" and highlighting the savings that would result for employers.[4]

Proponents emphasize that wellness incentives are voluntary. But the scenarios above show that voluntariness can become dubious for lower-income employees, if the only way to obtain affordable insurance is to meet the targets. To them, programs that are offered as carrots may feel more like sticks. It is worth noting that countries such as Germany generally use far lower reimbursements ($45 to $130 per year, or a maximum of 6% of an employee's contribution) and often use in-kind incentives (such as exercise equipment, heart-rate monitors, or vouchers contributing to the cost of a "wellness holiday") rather than cash.[3]

There are also questions about the effect on the therapeutic relationship. When the German Parliament passed a law making lower copayments conditional on patients' undergoing certain cancer screenings and complying with therapy, medical professionals rejected it, partly out of concern about being put in a policing position.[3] American physicians expressed concern when West Virginia's Medicaid program charged participating doctors with monitoring patients' adherence to the requirements set out in the member agreement.[5] Requiring physicians to certify an employee's medical unsuitability for an incentive scheme or to attest to their achievement of a target might similarly introduce an adversarial element into the doctor–patient relationship.

Incentives for healthy behavior may be part of an effective national response to risk factors for chronic disease. Wrongly implemented, however, they can introduce substantial inequity into the health insurance system. It is a problem if the people who are less likely to benefit from the programs are those who may need them more. The proposed increases in reimbursement levels threaten to further exacerbate inequities. Reform legislation should therefore not raise the incentive cap. Attainment incentives that primarily benefit the well-off and healthy should be phased out, and the focus should shift to participation-incentive schemes tailored to the abilities and needs of lower-paid employees. Moreover, it is crucial that the evaluation of pilots include an assessment of the socioeconomic and ethnic backgrounds of both users and nonusers to ascertain the equitability of programs.

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